GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# GEORGIA MEDICAID FEE-FOR-SERVICE
# HIV MEDICATIONS PA SUMMARY

| Preferred (not all inclusive) | Non-Preferred |
|---|---|
| Abacavir generic* | Abacavir/lamivudine/zidovudine generic |
| Aptivus (tipranavir) | Lamivudine solution generic |
| Atripla (efavirenz/emtricitabine/tenofovir)* | Nevirapine suspension generic |
| Complera (emtricitabine/rilpivirine/tenofovir) | Nevirapine extended-release generic |
| Crixivan (indinavir)* | Viramune XR (nevirapine extended-release) |
| Didanosine delayed-release generic* | |
| Edurant (rilpivirine) | |
| Emtriva (emtricitabine)* | |
| Epivir solution (lamivudine)* | |
| Epzicom (abacavir)* | |
| Evotaz (atazanavir/cobicistat) | |
| Fuzeon (enfuvirtide) | |
| Genvoya (elvitegravir/cobicistat/emtricitabine/tenofovir)* | |
| Intelence (etravirine) | |
| Invirase (saquinavir)* | |
| Isentress (raltegravir) | |
| Kaletra (lopinavir/ritonavir)* | |
| Lamivudine generic* | |
| Lamivudine/zidovudine generic* | |
| Lexiva (fosamprenavir)* | |
| Nevirapine immediate-release tablets generic* | |
| Norvir (ritonavir)* | |
| Prezcobix (darunavir/cobicistat) | |
| Prezista (darunavir) | |
| Rescriptor (delavirdine)* | |
| Reyataz (atazanavir)* | |
| Selzentry (maraviroc) | |
| Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir)* | |
| Sustiva (efavirenz)* | |
| Tivicay (dolutegravir)* | |
| Triumeq (abacavir/dolutegravir/lamivudine)* | |
| Trizivir (abacavir/lamivudine/zidovudine)* | |
| Truvada (emtricitabine/tenofovir)* | |

| | |
|---|---|
| Tybost (cobicistat) | |
| Videx Pediatric (didanosine)* | |
| Viracept (nelfinavir)* | |
| Viramune suspension (nevirapine suspension)* | |
| Viread (tenofovir)* | |
| Vitekta (elvitegravir) | |
| Zidovudine generic* | |

*PA not required

**LENGTH OF AUTHORIZATION:** 1 Year

**NOTES:**

- For preferred products, PA approval may be considered for members when faxed documentation is submitted of continuation of therapy from another insurance plan or ADAP (AIDS Drug Assistance Program).
- If generic nevirapine extended-release is approved, the PA will be issued for brand Viramune XR.

**PA CRITERIA:**

*For Abacavir/lamivudine/zidovudine*

- Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, brand Trizivir, is not appropriate for the member.

*For Aptivus*

- Approvable for members 2 years of age or older when used in combination with other antiretrovirals

*AND*

- Member's HIV must be resistant to protease inhibitors.

*For Complera*

- Approvable for antiretroviral-naïve members 18 years of age or older

*AND*

- For treatment-naïve, physician must submit faxed documentation of member's baseline HIV-RNA level at ≤100,000 copies/mL. For treatment experienced, member must have consistent viral suppression (HIV RNA <50 copies/mL) for >6 months with no history of virologic failure.

*For Edurant*

- Approvable for antiretroviral-naïve members 18 years of age or older when used in combination with other antiretrovirals

*AND*

- For treatment-naïve, physician must submit faxed documentation of member's baseline HIV-RNA level at ≤100,000 copies/mL.

*For Evotaz and Prezcobix*

- Approvable for member's 12 years of age or older when used in combination with other antiretrovirals.

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*For Fuzeon and Intelence*

- Approvable for members 6 years of age or older when used in combination with other antiretrovirals.

*For Isentress*

- Approvable for members 6 years of age or older when used in combination with other antiretrovirals.
- Isentress chewable tablets and powder are available for members less than 12 years of age who otherwise meet the criteria above.

*For Lamivudine Solution Generic*

- Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, brand Epivir Solution, is not appropriate for the member.

*For Nevirapine Suspension Generic*

- Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, brand Viramune suspension, is not appropriate for the member.

*For Nevirapine ER Generic and Viramune XR*

- Prescriber must submit a written letter of medical necessity stating the reason(s) the preferred product, generic nevirapine immediate-release tablets, is not appropriate for the member.

*For Prezista*

- Approvable for members 3 years of age or older when used in combination with other antiretrovirals.

*For Selzentry*

- Approvable for members 16 years of age or older when used in combination with other antiretrovirals

*AND*

- Physician must submit faxed documentation of CCR5-topic HIV-1.

*For Tybost*

- Approvable for members 18 years or older when used in combination with atazanavir or darunavir.

*For Vitekta*

- Approvable for members 18 years or older who are treatment-naïve when used in combination with other antiretrovirals.

**EXCEPTIONS:**

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

**PREFERRED DRUG LIST:**

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

**PA and APPEAL PROCESS:**

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

**QUANTITY LEVEL LIMITATIONS:**

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.